

SISC MEMBERSHIP CHANGE FORM

Please print clearly using a black or blue ink ballpoint pen.

District Name _____

REQUESTED EFFECTIVE DATE: _____ / _____ / _____

NAME OF SUBSCRIBER (LAST)	(FIRST)	SOCIAL SECURITY NUMBER	MEDICAL GROUP NUMBER
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NAME CHANGE	ADDRESS CHANGE
<input type="checkbox"/> Subscriber name only <input type="checkbox"/> Dependent(s)	New Address

NEW NAME	City/State/Zip
New Phone No. ()	

SUBSCRIBER CHANGES

CHANGE MY SOCIAL SECURITY NUMBER FROM: _____ TO: _____
(Please submit copy of Social Security card.)

CHANGE MY DATE OF BIRTH FROM: _____ TO _____

DEPENDENT CHANGES

ADD SPOUSE: Date of Marriage: ____/____/____ ADD DOMESTIC PARTNER Date of Partnership: ____/____/____
(Documentation is required for guardianship, adoptions and dependent re-enrollments.)

SPOUSE IS EMPLOYED AT SAME DISTRICT: _____ (Documentation must be on file with employer.)

ADD FAMILY MEMBER: Effective Date: ____/____/____ Reason: _____
(Documentation is required for guardianship, adoptions and dependent re-enrollments.)

REMOVE FAMILY MEMBER(S): Effective Date: ____/____/____ Name(s): _____ Reason: _____
(Documentation required. 30 days notice required for retro termination request.)

CHANGE DATE OF BIRTH FOR: _____ FROM: ____/____/____ TO ____/____/____

FAMILY ADDITIONS

RELATION	LAST NAME	FIRST NAME	M.I.	SOCIAL SECURITY NO.	Date of Birth	Age	Other Health Coverage	Qualified as IRS dependent	Full time student	Medical Group/PA Office No.	IPA Primary Care Physician Code	Is this your current doctor?
<input type="checkbox"/> SPOUSE/DP <input type="checkbox"/> male <input type="checkbox"/> female							<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no			<input type="checkbox"/> yes <input type="checkbox"/> no
<input type="checkbox"/> son							<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no			<input type="checkbox"/> yes <input type="checkbox"/> no
<input type="checkbox"/> daughter							<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no			<input type="checkbox"/> yes <input type="checkbox"/> no
<input type="checkbox"/> son							<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no			<input type="checkbox"/> yes <input type="checkbox"/> no
<input type="checkbox"/> daughter							<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no			<input type="checkbox"/> yes <input type="checkbox"/> no
<input type="checkbox"/> son							<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no			<input type="checkbox"/> yes <input type="checkbox"/> no
<input type="checkbox"/> daughter							<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no			<input type="checkbox"/> yes <input type="checkbox"/> no
<input type="checkbox"/> son							<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no			<input type="checkbox"/> yes <input type="checkbox"/> no
<input type="checkbox"/> daughter							<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no			<input type="checkbox"/> yes <input type="checkbox"/> no

SUBSCRIBER'S SIGNATURE _____ DATE _____